DESIGNER FAMILY DENTAL

info@designerfamilydental.com

www.DesignerFamilyDental.com

New Patient Information

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) _____ (Fax) _____ (Other)

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Please select the method(s) by which you prefer to receive appointment confirmations.(please select all that apply)

☐ Home phone ☐ Mobile phone ☐ Text message ☐ E-mail ☐ All

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT? (Name, relationship and phone #)

_____

Referral Source

Who may we thank for referring you to our office?

_____

EMPLOYER (name and phone):

_____

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Patient Medical History

Please check any medical alert that applies to you.

☐ *1-Gentle Cleaning	☐ *2-Moderate Cleaning	☐ *3-Aggressive Clean
☐ *Blood Thinners	☐ *Pre-Med - Amox	☐ *Pre-Med - Clind
☐ *Pre-Med - Other	☐ Allergy - Aspirin	☐ Allergy - Codeine
☐ Allergy - Erythro	☐ Allergy - Latex	☐ Allergy - Other
☐ Allergy - Penicillin	☐ Allergy - Sulfa	☐ Anemia
☐ Arthritis	☐ Artificial Joints	☐ Asthma
☐ Blood Disease	☐ Cancer	☐ Currently Pregnant
☐ Diabetes	☐ Epilepsy	☐ Excessive Bleeding
☐ Fainting/Dizziness	☐ Glaucoma	☐ Head Injuries
☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis: _____
☐ Herpes/Cold Sores	☐ High Blood Pressure	☐ HIGH DENTAL FEAR
☐ HIV	☐ Jaundice	☐ Kidney Disease
☐ Liver Disease	☐ Mental Disorders	☐ Nervous Disorders
☐ No Medical Alerts	☐ Osteoporosis Treatme	☐ Other
☐ Pacemaker	☐ Radiation Treatment	☐ Respiratory Problems
☐ Rheumatic Fever	☐ Seizures	☐ Sinus Problems
☐ Stomach Problems	☐ Stroke	☐ Tuberculosis
☐ Ulcers	☐ Unused	☐ Unused
☐ Unused	☐ Unused	☐ Venereal Disease

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Have you been treated with Bisphosphonate drugs (Fosamax, Aredia, Zometa, Actonel, Boniva)?

◯ Yes ◯ No

If so, when did the treatment begin and when did it end?

PREMEDICATION?

Have you ever been advised to take Premedication (an antibiotic) prior to dental appointments for a heart condition or joint replacement?

◯ Yes ◯ No

If yes, what Premedication do you take?

MEDICATION ALLERGIES?

◯ Medication Allergies (please answer following question)

◯ No Known Allergies (NKA)

Please list all medication allergies and their adverse reactions.

Please list all medications that you are currently taking.

If there is anything else you would like to inform us of, please note it here.

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NIDA (National Institute for Drug Abuse) Quick Screen

The questions below relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances are prescribed by a doctor (like pain medications). But we will only record those if you have taken them for reasons or in doses other than prescribed. You will also be asked about illicit or illegal drug use--but only to better diagnose and treat you.

IN THE PAST YEAR, how often have you used the following:

ALCOHOL
*For men, 5 or more drinks a day
*For women, 4 or more drinks a day

◯ Never ◯ Once or Twice ◯ Monthly
◯ Weekly ◯ Daily or Almost Daily

TOBACCO PRODUCTS

◯ Never ◯ Once or Twice ◯ Monthly
◯ Weekly ◯ Daily or Almost Daily

PRESCRIPTION DRUGS FOR NON-MEDICAL REASONS
(Non-medical use refers to using a substance either not prescribed to you directly or used in ways or amounts not prescribed by your doctor)

◯ Never ◯ Once or Twice ◯ Monthly
◯ Weekly ◯ Daily or Almost Daily

ILLEGAL DRUGS

◯ Never ◯ Once or Twice ◯ Monthly
◯ Weekly ◯ Daily or Almost Daily

* ☐ I CONSENT THAT THE PATIENT INFORMATION, MEDICAL HISTORY AND NIDA QUICK SCREEN ANSWERS PROVIDED ARE ACCURATE.

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Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Designer Dental Smile Design

What is the primary reason for your visit today?

- ☐ Tooth Pain
- ☐ I need a check-up/Cleaning
- ☐ Orthodontics
- ☐ Whitening/Cosmetic Dentistry
- ☐ Sedation Dentistry
- ☐ Other

Please rate your Dental Health from 1-5. Five being extremely Healthy.

_____

What would you like to see improved? (Select all that apply)

- ☐ Whiter, Brighter Smile
- ☐ Straightness of Teeth
- ☐ Bad Breath
- ☐ Less Sensitivity
- ☐ Fit of Partials/Dentures
- ☐ Bleeding Gums
- ☐ Other (please explain)

Are you interested in regular hygiene cleanings?

- ◯ Yes
- ◯ No

What has prevented you from following through with recommended treatment in the past?

- ☐ Fear
- ☐ Finances
- ☐ Office Hours
- ☐ Location
- ☐ Other

Why are you no longer seeing your previous dentist?

_____

COMMUNICATION ASSISTANCE?

- ◯ No communication assistance needed (NCAN)
- ◯ Translation needed

Primary Language Spoken

_____

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HIPAA (Privacy) Consent

* ☐ I AGREE TO THE NOTICE OF PRIVACY PRACTICES: (You have the right to request a copy)

Designer Dental Financial Policy

PATIENTS WITHOUT INSURANCE: Payment is due at the time of service.

PATIENTS WITH INSURANCE: All charges that you incur are ultimately your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer and the insurance company. Our practice is not a party to that agreement. We will not enter into any dispute with your insurance company, although we will provide necessary documentation that your insurance company requests to sort out any confusion or questions that may arise.

We will do our best to estimate the insurance portion with the information provided by your insurance company. We require that you pay your estimated copayment at the time of service. When more than 6 appointments are necessary to complete treatment, or when treatment is anticipated to exceed a 6 months duration, other payment options may be offered.

We file all claims electronically, on the date of service. Insurance payments are ordinarily received within 30 days. When payment is not received within that time, we will follow up with the insurance company on your behalf and expect payment within another 30 days. Any insurance balance not received within 60 days will be the responsibility of the patient and will become immediately due. At that time we will ask that you pay the balance and seek reimbursement directally from your insurance company.

PAST DUE BALANCES: All balances older than 60 days will be subject to finance charges at the rate of 18% per month, and may incur collection fees.

PAYMENT OPTIONS: Cash, Checks, Master Card, Visa, Care Credit & Discover card.

* ☐ I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THIS FINANCIAL POLICY. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO DESIGNER DENTAL.

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Consent for Release of Information

Instructions for using this form:

Completing this form will allow us to give informaton or records about you to another individual or group. You must complete all required fields. We will not honor your request unless all required fields are completed. (*signifies a required field).

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

I authorize Designer Family Dental to release information or records about me to:

*1-Name, Relationship to Patient and Phone Number (all information must be provided)

*Records/Information allowed to release: (check all that apply)

☐ X-rays ☐ Treatment ☐ Financial ☐ Any and All

*Reason for releasing information:

*2-Name, Relationship to Patient and Phone Number (all information must be provided)

*Records/Information allowed to release: (check all that apply)

☐ X-rays ☐ Treatment ☐ Financial ☐ Any and All

*Reason for releasing information:

* ☐ I AM THE INDIVIDUAL TO WHOM THE REQUESTED INFORMATION OR RECORD APPLIES, OR THE PARENT OR LEGAL GUARDIAN OF A MINOR, OR THE LEGAL GUARDIAN OF A LEGALLY INCOMPETENT ADULT.

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24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, Designer Family Dental reserves the right to charge a fee of $75.00 for all missed appointments ("no shows") and appointments, which, when absent a compelling reason, are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient. This fee is not covered by insurance, and must be paid prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all of our patients.

* ☐ I ACKNOWLEDGE THAT I HAVE RECEIVED THIS NOTICE AND UNDERSTAND THE POLICY

Informed Consent

BY SIGNING BELOW YOU:
*Confirm the patient information, medical history and NIDA quick screen is accurate
*Confirm you have been given the opportunity to request a copy of the HIPAA Notice of Privacy Practices
*Acknowledge that you understand our Financial Policy
*Give authorization for your insurance company to pay your dental benefits directly to Designer Family Dental
*Consent to release information to the individual(s) or group(s) listed under "Consent for Release of Information"
*Acknowledge that you have received and understand our "24 Hour Cancellation & No Show Fee Policy"

Signature: _____ Date: _____

Relationship (if not the subject of the record) and Daytime Phone Number

_____

Response Date: _____